Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ORTHOTEXAS PHYSICIANS AND SURGEONS
4780 N JOSEY LANE
CARROLLTON TX 75010

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-12-1412-01

Carrier's Austin Representative Box
Box Number 05

MFDR Date Received
JANUARY 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as Listed on the Table of Disputed Services: "filed electronically insurance denied as timely filing submitted clearinghouse report that insurance received bill appealed and insurance still denied for timely filing"

Amount in Dispute: $913.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider performed the services and submitted billing to their electronic billing partner, Realmed. The billing was ultimately received by the Carrier and denied based on the failure to timely submit the billing. The Provider requested reconsideration, and the Carrier upheld the denial of reimbursement…The Provider alleges they timely submitted the billing through their e-bill vendor, Realmed. In support of that contention, the Provider submits documentation from Realmed purporting that the billing was 'Confirmed by the payor or client.' The Carrier has reviewed the medical billing records on this claim for this Provider and confirmed the billing for both dates of service was received on 09-27-2011…The Carrier has no record of providing a confirmation to Realmed, and cannot comment on Realmed's assertion that they received confirmation, from whom the confirmation was received, or what that confirmation contained. The Carrier would point out the Realmed's confirmation does not state from whom confirmation was received…As documented by the attached HCFA-1500s, the Carrier received billing for both dates of service on 09-27-2011…The bill was, therefore, not submitted timely to the Carrier, and reimbursement was properly denied."

Response Submitted by: Travelers, 1501 S. Mopac Expressway, Suite A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2011	CPT Code 64622 CPT Code 64623 CPT Code 64623 CPT Code 77003-26-59	$446.27 $164.48 $164.48 $42.43	$446.27 $164.48 $164.48 $42.43
April 25, 2011	CPT Code 99213	$95.92	$95.92
TOTAL		$913.58	$913.58

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 29, 2011
   - TXH3 – 29 – THE TIME LIMIT FOR FILING HAS EXPIRED. PER TEXAS LABOR CODE 480.027, BILLS MUST BE SENT TO THE CARRIER ON A TIMELY BASIS, WITHIN 95 DAYS FROM DATES OF SERVICE.

   Explanation of benefits dated October 6, 2011
   - TXH3 – 29 – THE TIME LIMIT FOR FILING HAS EXPIRED. PER TEXAS LABOR CODE 480.027, BILLS MUST BE SENT TO THE CARRIER ON A TIMELY BASIS, WITHIN 95 DAYS FROM DATES OF SERVICE.

   Explanation of benefits dated November 10, 2011
   - W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds that the requestor has supported that the provider, filed for reimbursement within 95 days after the date of service. The submitted documentation supports that the bills were confirmed sent to and received by the providers billing agent, RealMed, on May 11, 2011. Per 28 Texas Administrative Code §102.4(h), documentation submitted by the requestor in this medical fee dispute sufficiently supports that a medical bill was submitted for payment to the insurance carrier within 95 days after the date on which the health care services were provided to the injured employee.

3. Review of the submitted documentation finds that the requestor in this medical fee dispute has timely filed the medical bills with the insurance carrier in accordance with Texas Labor Code §408.027. The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines.

   Per 28 Texas Administrative Code §134.203, the calculations for CPT code 64622 is as follows:

   $54.54 WC CF/33.9764 Medicare CF x $321.76 Participating Amount = $516.50

   The total MAR for CPT code 64483 billed on March 3, 2011 is $516.50. The requestor's *Table of Disputed Services* lists a disputed amount of $446.27, therefore, this amount is recommended.

   Per 28 Texas Administrative Code §134.203, the calculations for CPT code 64623 is as follows:

   $54.54 WC CF/33.9764 Medicare CF x $119.80 Participating Amount = $192.31

   The total MAR for CPT code 64483 billed on March 3, 2011 is $192.31. The requestor's *Table of Disputed Services* lists a disputed amount of $164.48, therefore, this amount is recommended.

   Per 28 Texas Administrative Code §134.203, the calculations for CPT code 64623 is as follows:

   $54.54 WC CF/33.9764 Medicare CF x $119.80 Participating Amount = $192.31

   The total MAR for CPT code 64483 billed on March 3, 2011 is $192.31. The requestor's *Table of Disputed Services* lists a disputed amount of $164.48, therefore, this amount is recommended.

   Per 28 Texas Administrative Code §134.203, the calculations for CPT code 77003-26-59 is as follows:

   $54.54 WC CF/33.9764 Medicare CF x $29.03 Participating Amount = $46.60

   The total MAR for CPT code 77003-26-59 billed on March 3, 2011 is $46.60. The requestor's *Table of Disputed Services* lists a disputed amount of $42.43, therefore, this amount is recommended.

   Per 28 Texas Administrative Code §134.203, the calculations for CPT code 99213 is as follows:

   $54.54 WC CF/33.9764 Medicare CF x $66.90 Participating Amount = $107.39

   The total MAR for CPT code 99213 billed on April 25, 2011 is $107.39. The requestor's *Table of Disputed Services* lists a disputed amount of $95.92, therefore, this amount is recommended.

Conclusion

Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $913.58.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $913.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 22, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.